BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ROBERT H. JOCHIM, M.D.** License No. 7074 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-09-0424A **ORDER FOR LETTER OF REPRIMAND AND CONSENT TO SAME CONSENT**

CONSENT AGREEMENT

Robert H. Jochim, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 7074 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-09-0424A after receiving a complaint regarding Respondent's care and treatment of multiple patients. During the Board's investigation, four patient charts were reviewed and deviations were found in three charts.

4. Patient IH presented to Respondent for prenatal care at 23 weeks gestation. There was no documented physical or pelvic examination. Respondent ordered laboratory tests that included a pap smear and cultures, but he did not send the tests to the lab. Respondent prescribed Keflex without documenting the reason for the prescription. Two months later, IH was admitted to the hospital with abdominal pain and contractions. An exam revealed an infiltrating mass of the posterior vagina to the level of the vulva. A

biopsy was taken of the mass that revealed adenocarcinoma of the rectum. IH was subsequently treated for the malignancy.

5. Patient LJ presented for prenatal care at 28 weeks gestation with noted obesity and a history of macrosomia and gestational diabetes mellitus (DM). Respondent discussed her weight and the option of a cesarean section (C-section); however, LJ refused a C-section unless it was necessary. There was no documentation that Respondent evaluated LJ for the possibility of a macrosomic infant that could develop a brachial plexus injury. Respondent ordered a one-hour glucose tolerance test (GTT) that showed an elevated blood sugar level. He later ordered a three-hour GTT, but there was no evidence that it was completed. Subsequently, LJ was admitted to the hospital at 39 weeks gestation. Respondent performed a low forceps delivery with shoulder dystocia, a nuchal cord and true knot identified. The infant was transferred to another hospital when a left atrial mass was identified. The infant was diagnosed with a brachial plexus injury.

6. On May 15, 2008, patient KB presented to Respondent for prenatal care at 28 weeks gestation. A one-hour GTT showed an elevated blood sugar level. A three-hour GTT was ordered; however, there was no documentation that it had been performed. Subsequently, KB presented to Respondent on several occasions from May 2008 through June 2008 without further evaluation of her elevated blood sugar levels.

7. The standard of care when a patient presents for prenatal care requires a physician to conduct a complete examination that includes a physical and pelvic exam and to order appropriate laboratory studies that includes a pap smear test and cultures. When a patient presents for prenatal care and has an elevated blood sugar, the standard of care requires a physician to evaluate the patient for gestational diabetes and if found, the patient should be treated with continued maternal and fetal evaluations. The standard of care when a patient presents with a history of macrosomia, gestational DM and obesity

requires a physician to evaluate the patient for the possibility of a macrosomic infant that could develop brachial plexus injury.

8. Respondent deviated from the standard of care because he did not conduct a complete examination on patient IH that included a pelvic examination and he did not send the pap test and cultures to the lab. Respondent also deviated from the standard of care because he did not provide continued maternal and fetal evaluations for patients LJ and KB for gestational DM. Respondent deviated from the standard of care because he did not evaluate LJ for the possibility of a macrocosmic infant that could develop brachial plexus injury.

9. Respondent's failure to examine IH upon presentation created a delay in the diagnosis of an infiltrating rectal adenocarcinoma and a delay in treatment. Respondent's failure to evaluate LJ for the possibility of a macrocosmic infant led to the infant sustaining a brachial plexus injury. LJ was also at increased risk for intrauterine fetal death. Respondent's failure to complete the three-hour GTT placed KB at risk for complications of gestational DM if were identified on the three-hour GTT.

10. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because there were no documented physical or pelvic examination for IH, he prescribed Keflex to IH without documenting the reason for the prescription, and there was no documentation that he evaluated LJ for the possibility of a macrosomic infant.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent shall within **one year** obtain of the effective date of this Order obtain **10 - 15 hours** of Board Staff pre-approved non-disciplinary Category I Continuing Medical Education (CME) in **medical recordkeeping** and shall provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

DATED AND EFFECTIVE this 2nd day of DECEMBER, 2009.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

11. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

Robert H. Jochim

ROBERT H. JOCHIM, M.D.

DATED: 10/1/09

EXECUTED COPY of the foregoing mailed this 2nd day of December, 2009 to:

Calvin Raup
Raup & Hergenroether PLLC
One Renaissance Square
Two N. Central Avenue, Suite 1100
Phoenix, Arizona 85004-0001

EXECUTED COPY of the foregoing mailed this 2nd day of December, 2009 to:

Robert H. Jochim, M.D.
Address of Record

ORIGINAL of the foregoing filed this 2nd day of December, 2009 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Arizona Medical Board Staff